Deprescribing in Primary Care: Getting started

Project MO1: Funded by the Polypharmacy Project Call 2019

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Summary

This report describes a deprescribing project which took place between May 2019 and October 2019 as the result of a funding call for polypharmacy proposals by the Academic Health Sciences Network North East and North Cumbria Medicines Optimisation programme. The aim of the project was to create a series of tools to support deprescribing in primary care, where barriers had been identified by the project team.

The project used a Human Centred Design approach, with a linked series of activities to iteratively design tools which would support the deprescribing process. This included identification of available deprescribing tools, prioritisation of deprescribing messages and finally developing design ideas using a process of ‘prototyping’. Clinicians across primary and secondary care within South Tyneside and Sunderland, as well as patients were involved in the project to support this design process.

Through the three workshops which were held during the course of the project, common themes were identified around potential barriers and facilitators to deprescribing in the primary care setting. These included how to communicate with patients about the potential for medicines to be discontinued and providing clear guidance for prescribers to support deprescribing decisions.

The output from the project was the idea to create a deprescribing ‘brand’ which could be used to raise the profile of deprescribing across several tools. By creating a visual ‘brand’ which could be used in guidance documents, training materials and patient facing communications it may increase consistency of approach to deprescribing across primary care. The intention is for this to be developed following on from this project and for the materials to be tested alongside the launch of a clinical guideline for diabetes in Sunderland and South Tyneside.

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Introduction

Despite the availability of a variety of deprescribing tools, active deprescribing in general practice is low. Feedback from GPs suggests that the large number of indicators, and lengthy documents to support deprescribing reduce the accessibility of the information and confidence of primary care clinicians to deprescribe.

This project aimed to support the first steps to start deprescribing in general practice. This included:

- prioritisation of deprescribing messages that primary care should initially try to implement
- development of tools to support implementation of these deprescribing messages

Methods

This project drew on a range of techniques to support the engagement of clinicians and patients to develop a deprescribing toolkit which could be flexibly used across the local health economy of Sunderland and South Tyneside.

It was recognised that involvement of secondary care clinicians was key to ensuring that deprescribing messages delivered in primary care had the support of expert clinicians. The first step in the project was a prioritisation workshop to try and achieve consensus around which deprescribing messages were most important to implement in the general practice setting. This workshop used Nominal Group Technique (NGT)[1] to achieve this consensus.

Following the generation of the agreed deprescribing messages, Human Centred Design (HCD) was used to develop potential tools which could be used to support the implementation of these messages. The model of human centred design used was that published by IDEO[2] which exists as a toolkit of methods which can be used to develop design ideas. They recommend breaking down the process of design into ‘Inspiration’, ‘Ideation’ and ‘Implementation’. This project focussed firstly on ‘Ideation’ which is the process of learning from the end users of the design about their perspectives, in this case general practice staff and their thoughts on deprescribing. This was followed by ‘Ideation’ which supports a broad approach to generating ideas and working these up in tangible ‘prototypes’.

Project delivery

The project was delivered in four stages:

1. Analysis of recognised deprescribing tools to identify all possible deprescribing messages for consideration to be implemented in the general practice setting
2. A consensus workshop to prioritise a small number of messages (3-5) to use as the basis for designing deprescribing tools
3. An ‘Inspiration and Ideation’ workshop with primary care clinicians to start the design process for creating the deprescribing tools
4. A ‘Prototyping’ workshop where ideas from primary care were further developed into initial prototype ideas with a mixture of secondary care clinicians, primary care clinicians and patients

Stage 1: Analysis of deprescribing tools

Deprescribing tools were identified through searches of the published literature and well known publishers of medicines guidance including the National Institute for Health and Care Excellence (NICE), the Royal Pharmaceutical Society and PrescQIPP. Google searches were also conducted. Tools were considered if:

- They were validated or drawn from high quality guidance (such as NICE)
- Were specific about recommendations for clinical scenarios where medicines should be reviewed with a view to stopping where appropriate

Where local guidelines were identified, source documents for those recommendations was identified.

Seven sets of deprescribing guidance were identified for inclusion, which included:

- Beers Criteria (2015 Update)[3]
- Canadian Deprescribing Network (CaDeN)[4]
- IMPACT (Improving Medicines and Polypharmacy Appropriateness Clinical Tool)[5]
- STOPP/START criterial for potentially inappropriate prescribing in older people (version 2)[6]
- STOPPFrail (Screening Tool of Older Persons Prescriptions in Frail Adults with limited life expectancy)[7]
- NHS Scotland Polypharmacy Indicators[8]
- PINCER[9]

Guidance with more generic guidance such as the NHS Scotland Polypharmacy 7-steps to Medication Review[10], NO TEARS[11] and the WHO Polypharmacy Report[12] were excluded.

Once tools were identified, they were mapped against clinical speciality (see Table 1) so that potential participants from secondary care could be identified for invitation to the prioritisation exercise.

	Deprescribing Tool							
Clinical speciality	STOPP Frail	PINCER	CADEN	IMPACT	Beers	NHS Scotland	STOPP	Total
Cardiology	✓	✓		✓	✓	✓	✓	6
Dementia	✓		✓	✓	✓	✓	✓	6
Depressive disorders				✓	✓	✓		3
Diabetes	✓		✓		✓	✓		4
Gastroenterology	✓		✓	✓	✓		✓	5
Nephrology					✓	✓		2
Neurology				✓	✓	✓	✓	4
Nutrition	✓			✓				2
Orthogeriatrics	✓	✓		✓	✓	✓	✓	6
Pain	✓	✓		✓	✓	✓	✓	6
Respiratory	✓	✓		✓		✓		4
Rheumatology	✓							1
Urology	✓			✓	✓		✓	4
Women's health	✓				✓	✓		3

Table 1: Identified deprescribing guidance mapped to clinical speciality

Stage 2: Workshop to select deprescribing messages with secondary care

The next step for the project was to filter the deprescribing messages identified in Stage 1 using expertise from secondary care. The aim was to identify a small number of messages which could be taken forward to consider potential implementation tools in primary care. This endorsement of deprescribing messages from secondary care had been identified as important to primary care clinicians as part of the project proposal development.

Participants

Invitations were sent to secondary care clinicians identified from the mapping exercise (see Table 1). Initially there was sign-up from six people, however due to work commitments at the final workshop there was only representation from four participants. These included:

- A specialist cardiology pharmacist
- A specialist frailty pharmacist
- A diabetes consultant
- An old age psychiatrist

Approach

Individual packs were created which contained all of the deprescribing messages mapped to that clinician's speciality alongside the source from which they were taken. Copies of the original reference sources were also made available for workshop participants. The agenda for the workshop was based on NGT methods and made up of five tasks:

1. Deprescribing message filtering by individual clinicians
2. Sharing of selected deprescribing messages with the group for consideration for selection
3. First round of ranking
4. Ranking discussion
5. Second round of ranking

Ranking was completed by providing each participant with the option to select three deprescribing messages with a rank of one to five with one representing the most important message to prioritise and five being the least important. The participants were advised to base their ranking of importance on both:

- The impact of over-prescribing in this area, including consideration of patient health outcomes, unplanned hospital admissions and costs to the NHS (in either primary or secondary care)
- The likely ability of primary care to implement the message including likely familiarity with the drug and the risks/ benefits of deprescribing and any potential requirements for monitoring/ review following deprescribing

Ranks were converted into an overall score by converting each of the ranks into number (1 = 5 points, 2 = 2 points etc) and then added together for each rank that was allocated to a deprescribing message by the participants. This allows an overall rank to be generated for all of the messages which takes into account the ranking decisions of all participants. It also allows those messages of least importance to be identified (as no rank is allocated to them) and focuses the ranking in a second round on a smaller number of messages. To facilitate the second round of ranking, each clinician explains why they ranked the messages the way that they did and provides an opportunity to build consensus and for others to be persuaded about which messages are most important to inform ranking choices in the second round.

Findings

Deprescribing message filtering by individual clinicians

In Task 1, each speciality clinician was asked to choose up to five messages from their clinical area for consideration by the group. This resulted in 15 messages which were presented to the group for discussion (see Table 2). Following the first round of ranking, six indicators received no votes to consider them in the second round and were eliminated. Following discussion of ranking choices amongst clinicians, some messages were modified. Changes are highlighted in Table 2. Re-ranking in the second round identified five indicators with the highest score. However, following discussion the clinicians felt that a message around z-drugs and benzodiazepines could be combined into a single message. The rationale was that the patient population and the challenges associated with this message would be similar to both sets of drugs. A larger programme of work was also being completed by NHS Sunderland CCG around opioids, so these messages were also removed from consideration.

The final agreed messages to take through to the design phase were:

For patients who are moderately to severely frail, consider deprescribing where there is a prescription for:

- Benzodiazepines or z-drugs where there is a history of falls or fractures
- Tricyclic antidepressants for pain or night sedation, where there is a history of falls or fractures
- Long-acting sulfonylureas for diabetes (glibenclamide, glimepiride, modified release gliclazide)

Deprescribing message	Source	Round 1 Score	Round 2 Score
Prescription for benzodiazepines for elderly adults (≥ 65 y)	CaDeN BEERS CRITERIA	-	-
Prescription for benzodiazepines for adults (18 to 64 years) who have used benzodiazepines most days of the week for > 4 weeks	CaDeN BEERS CRITERIA	-	-
Prescription for Eszopiclone / Zaleplon / Zolpidem where there is a history of falls / fractures	BEERS CRITERIA	8	8†
Prescription for bisphosphonates, if the patient has been taking for 5 years or more.	IMPACT	-	-
Prescription for benzodiazepines where there is a history of falls or fractures	BEERS CRITERIA	15	15†
Prescription for opioids where there is a history of falls or fractures	BEERS CRITERIA	3	4
Prescription for tricyclic antidepressants where there is a history of falls or fractures (used for pain or night sedation)*	BEERS CRITERIA	8	9†
Prescription of warfarin or direct oral anticoagulants in combination with an oral NSAID.	PINCER BEERS CRITERIA	2	-
Prescription for omega 3 fatty acid supplements	IMPACT	-	-
Prescription for statins / lipid-Lowering drugs for primary and secondary prevention of cardiovascular disease in those with a low risk profile and older patients (with moderate to severe frailty)*	IMPACT	1	-
Prescription for aspirin for primary prevention	IMPACT	-	-
Prescription for Nicorandil for angina, if ulceration of the GI tract, skin or mucosa occurs	STOPP START	-	-
Prescription for peripheral alpha-1-blockers for hypertension	BEERS CRITERIA	3	3
Prescription for long-acting sulfonylureas in older people	BEERS CRITERIA	9	4†
Prescription for Metformin in eGFR is below 30mL/min/1.73m^2	STOPP START	5	2

* These are amendments made by the group to the original deprescribing message
† These indicators were selected by the group to move to the design phase

Table 2: Results of prioritisation exercise from workshop 1 with secondary care

Stage 3: Workshop to explore barriers and facilitators to the implementation of selected deprescribing messages in primary care

The aim of this second workshop was to generate initial design ideas which could support the implementation of the deprescribing messages generated in the first workshop.

Participants

Invitations were distributed via NHS Sunderland CCG general practice mailing lists. The intention was to have a mixture of General Practitioners (GPs), General Practice Pharmacists (GPPs) and Practice Nurses (PNs) included as participants. Thirteen participants were present on the day including seven GPs, five GPPs and one practice nurse. These participants were split across three groups, one for each of the deprescribing messages prioritised from Workshop 1.

Approach

In order to ensure that design ideas were rooted in the experience of those clinicians working in primary care and to support the 'Inspiration' step of the HCD process, a 'Card Sort' exercise was undertaken. Cards were created which contained words which were linked to deprescribing in the guidelines identified and the experience of the project group.

Each workshop group was asked to select cards which they felt represented some of the challenges they faced in deprescribing. A word cloud which highlights the words selected by the groups by displaying these in larger text can be seen in Figure 1.

Figure 1 Word cloud from card sort exercise

Following on from this, each workshop group was asked to define their design challenge to implement their allocated deprescribing message using 'How might we…' statements. These are designed to articulate the specific problem that requires a design solution as part of the 'Ideation' process in the HCD framework. Each group was asked to construct "How might we…" statements for each of the deprescribing messages. They were then asked to select three of these to generate design ideas for.

Following the generation of 'How might we…' statements, participants were asked to 'Brainstorm' ideas for meeting the challenge of the 'How might we…' statement. These were then filtered this using a 'Gut check', where the most promising ideas are prioritised. These ideas were then further developed using 'Storyboarding' where participants outline how their design idea would work in practice by describing what would happen, when and with whom.

Findings

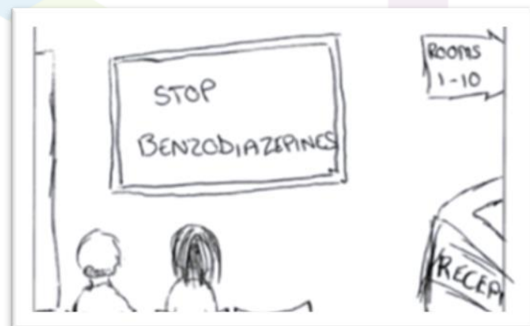
For patients who are moderately to severely frail, consider deprescribing where there is a prescription for benzodiazepines or z-drugs where there is a history of falls or fractures

How might we… statements generated by this group included:

- How might we educate the public about the risks of benzodiazepines / z-drugs?
- How might we avoid/manage patient complaints?
- How might we get a consistent approach to prescribing for everyone?
- How might we include families in the conversation?
- How might we prepare patients for a conversation about their benzodiazepines / z-drugs?
- How might we frame the conversation about deprescribing (give rather than take away)?
- How might we share positive stories about stopping benzodiazepines / z-drugs?
- How might we increase capacity for reduction clinics?
- How might we get patients to consider decisions outside of appointments?

Most promising idea from the group 'Brainstorm' and 'Gut Check': A public communications campaign to educate the public about the risks of benzodiazepines and z-drugs

A communications campaign which can be used in general practice screens to educate the public about the potential of stopping benzodiazepines.



Use of patient stories which can be used as examples of the benefits of stopping benzodiazepines and z-drugs.

Use secondary care to also display messages to capture patients who may be admitted with falls which could have been caused by benzodiazepines or z-drugs.

For patients who are moderately to severely frail, consider deprescribing where there is a prescription for tricyclic antidepressants for pain or night sedation, where there is a history of falls or fractures

How might we statements generated by this group included:

- How might we identify frailty?
- How might we sell "deprescribing" to the patient?
- How might we actually deprescribe safely and appropriately?
- How might we reduce variation?
- How might we engage secondary care with this issue? (i.e. Pain Team)
- How might we consider suitable alternatives?
- How might we manage patient expectations? – "I've only had five hours sleep"
- How might we stop / reframe "GP to review"?
- How might we develop/adopt robust guidelines?
- How might we maintain patient/ prescriber relationships?
- How might we empower patients to choose healthy alternatives?

Most promising idea from 'Brainstorm' and 'Gut Check': Patient searches of GP clinical systems to identify and invite patients for review with GPP support.

For patients who are moderately to severely frail, consider deprescribing where there is a prescription for long-acting sulfonylureas for diabetes (glibenclamide, glimepiride, modified release gliclazide)

How might we statements generated by this group included:

- How might we create a diabetes deprescribing guideline?
- How might we define the right cohort of patients?
- How might we use guidelines appropriately to allow supported deprescribing?
- How might we improve conversations on initiation of medicines e.g. do not say ''you will be on this forever''.
- How might we communicate better with all in GP Practice?
- How might we share deprescribing decisions within GP practice and secondary care?
- How might we empower staff to deprescribe?
- How might we focus on key points in time given for review?
- How might we create longer and more appointments? Including a skill mix of pharmacists and nurses.
- How might we stop people saying ''you will be on this for the rest of your life''?
- How might we create triggers for a deprescribing review?
- How might we reduce risk of unwanted consequences?
- How might we take the fear out of the process?
- How might we adjust patient expectations?

Most promising idea from 'Brainstorm' and 'Gut Check': Patient searches of GP clinical systems to identify and invite patients for review with GPP support.

Stage 4: Workshop to prototype design ideas to support deprescribing in primary care

The aim of this final workshop was to further develop design ideas from the previous primary care workshop, ready for developing some new tools to support deprescribing in the primary care setting.

Following the second workshop, the project group reflected on the two ideas developed by two of the groups which came up with using patient searches to invite people for medication review. Whilst this idea is valid, this was felt to be a well-recognised way of supporting medication review in primary care. Guidance during the 'Gut Check' to choose things which participants felt would work seemed to result in ideas which were familiar. The design of this approach is also well tested and the project group felt it didn't require further design development.

However, the group did feel that there were some important points raised which could support the ideas which were identified, but using tools which would warrant further consideration. To identify designs to develop in the third workshop, the project team took inspiration from the "How might we…" statements. Within these there were some common themes across the groups including:

- Communicating the benefits of deprescribing to patients
- Supporting clinicians to make deprescribing decisions
- Ensuring that long-term medicines aren't communicated as being "for the rest of your life"

So it was these that were chosen for development in the third workshop. The designs which groups were asked to develop were:

- A communications campaign around the message "You might be better without some medicines"
- A sample of how deprescribing sections could be incorporated into clinical guidelines (using diabetes as an example which was currently being planned for Sunderland and South Tyneside)
- Creating an alternative to the phrase "You'll be on this for the rest of your life"

Participants

Participants who either attended or expressed an interest the previous workshops were invited to attend. Additionally, the project team felt it would be useful to include patients in this workshop and so an invitation for attendees was distributed via the NHS Sunderland CCG 'My NHS' distribution list. Specific participants were also invited to support the specific designs.

The group working on a design for a *communications campaign* around a deprescribing message included a secondary care frailty pharmacist and two members of NHS Sunderland CCG admin team, one of whom has experience in communications. The group working to design a sample *deprescribing guideline section* included the medicines optimisation lead for the Sunderland and South Tyneside diabetes guideline, a GP and a GPP. The group creating an *alternative phrase to "You'll be on this for the rest of your life"* included a GP, a GPP and a secondary care clinician. Two patients were recruited and spent time with each of the three groups to give feedback on ideas and to be involved in the design creation.

Approach

This third workshop continued the HCD process and included an element of prototyping. This places an emphasis on making ideas tangible through the use of diagrams, roleplay, and models. These prototypes can then be used as basis for more detailed discussion about what might work and what needs to be further developed. Facilitators were briefed around prototyping and given some guidance for working up the design ideas.

<u>Communications campaign</u>

Following advice from a communications expert, the group developing the design for the communications campaign aimed to answer the following questions:

- What do you want the audience to know?
- What is the message?
- Who is the audience?
- How might the message be delivered?

Using these questions was intended as a way of creating a briefing which could be used to commission a future communications campaign with the information that a provider would need to develop this.

<u>Sample deprescribing section for a guideline</u>

This group was facilitated using the AGREE II framework for guideline development to explore how deprescribing recommendations should be formulated and disseminated to clinicians. AGREE II is a guideline appraisal tool which describes six domains which make up the quality of a clinical guideline. By using this as a framework, the group could explore how to create high quality deprescribing guidance.

<u>Alternative to “You’ll be on this for the rest of your life”</u>

As the use of this phrase is behaviour, the Behaviour Change Wheel (BCW) was used as the basis for developing the ideas for this design. This included defining this as a behaviour, designing an alternative phrase and considering what behaviour change techniques might be helpful to encourage people to use this new phrase instead of “You’ll be on this for the rest of your life”. The BCW is a well recognised behaviour change approach which has been used in a lot of different health behaviours.

Findings

Communications campaign

The group explored the communications questions to support the design of a communications campaign to prompt patients to think about whether they might be better off without some of their medicines. The ideas generated by the group can be found in Table 3 below.

What do you want the audience to know?	Who is the audience?
Medicines can do more harm than good Medicines may not be appropriate any longer, as circumstances change Medication Review – Do you think it's time to have one? Time is a big thing but a medication review is a valuable thing to do. 15 to 30 minutes to change your life.	Patients Family members Carers Clinicians GP practice staff
What is the message?	**How might the message be delivered?**
Do you suffer from headaches; feel sick, dizzy or tired? Are your medicines still right for you? Talk it over with your GP, Pharmacist or Practice nurse because sometimes having a break can make you feel better. Together you can decide. Medicines aren't the only answer	GP screens and posters Radio Health champions Flu vaccine time On-line pop-ups Social media Other networks e.g. local authorities Fully accessible - language – easy to read Patient stories starting with "I felt tired…dizzy…etc.…"

Table 3: Results from the communications campaign group in the third workshop

Sample deprescribing section for a guideline

The group explored the following domains of the AGREE II framework for guidelines which produced a range of recommendations for developing deprescribing guidance.

Scope and purpose

It was considered to be important to the group that deprescribing guidance should be across primary and secondary care.

Stakeholder involvement

It was acknowledged that a wide range of stakeholders needed to be involved in the development of deprescribing guidance, but that this needed to be tempered to ensure that this did not hold up the guideline development time plan.

Rigour of development

It was recognised that the evidence base for deprescribing recommendations was weak, however there was support for local expert opinion to be a sound basis for deprescribing recommendations as an appropriate substitute.

Clarity of presentation

The group felt that deprescribing guidance needed to be easy to read and be able to function as a 'quick reference guide'. There was a desire for deprescribing recommendations to appear both as a summary sheet but also appearing within the main body of the guideline which would be cross-referenced by the summary. Being prescriptive about how to deprescribe safely and effectively was also considered to be important. Group members also identified that the guidance recommendations need to be written for a lot of different clinician types including GPs, nurses and pharmacists. The guidance should be useable by all of these professional groups. A uniform template was suggested as something which could be helpful to use.

Applicability

To support guideline implementation, suggestions included face-to-face training sessions with clinicians which included a clear 'patient facing' reason as to why deprescribing was important. A position statement on deprescribing linked to the risks of inappropriate polypharmacy and why this is a local priority were suggested as important for implementation. Peer-to-peer sharing of experiences of cases where deprescribing had been done successfully was identified as a good way of supporting deprescribing. The group also generated suggestions for ways in which deprescribing could be embedded into general practice though the use of review dates for medicines in patient records. There was also consideration around methods of guideline dissemination including the potential use of digital platforms. Involving patients in deprescribing decisions was deemed to be important.

Alternative to the phrase “You’ll be on this for the rest of your life”

The BCW suggests defining a behaviour in terms of who is performing it, where are they doing it, when the behaviour occurs and with whom. For the phrase “You’ll be on this for the rest of your life” the group defined the behaviour as outlined in Table 4.

What?	Saying “you’ll be on this for the rest of your life”
Who?	GPs, practice nurses, community pharmacists, consultants, nurse practitioners, hospital pharmacists, district nurses, social carers, family, general practice, hospital, care home staff, NHS 111, paramedics.
Where?	Patients’ home, pharmacies, general practices, hospitals, care homes, on the phone, in an ambulance
When?	At first prescribing, at medication review, when nonadherence is revealed by a patient, when family/patient ask “why” they are taking the medicine
With whom?	Patients, patients’ families/carers, with other healthcare providers

Table 4: Behaviour definition for “you’ll be on this for the rest of your life”

Following this definition, the group then brainstormed what should be the replacement phrase which could be used instead of this. The aim from the group was to remove the certainty of continuous medication and support patients and professionals to consider when medication might no longer be appropriate. The final phrase which was considered to be best was:

“You’ll be on this as long as it’s working for you”

The group also highlighted that this had the potential for adaption to the different scenarios which were identified in the behavioural definition including at prescribing initiation, at medication reviews and for patient facing communication materials. The ambiguity of the word “working” was considered to be a good way of highlighting that this would be open to interpretation and could be considered differently by patients and clinicians and also potentially open up a conversation about the wider risks/ benefits of treatment.

Barriers to change this as a behaviour were also identified, alongside behaviour change intervention functions which could be used to change this. Intervention functions are identified in the behaviour change wheel as mechanisms which can be used to change behaviour. For this behaviour, the intervention function persuasion was identified as being potentially helpful to support this change in practice. Persuasion describes the process of persuading people to change their behaviour. This then led to identifying useful behaviour change techniques (BCTs) which could be used to encourage clinicians to stop saying “you’ll be on this for the rest of your life” and change to “you’ll be on this as long as it’s working for you”.

Behaviour change techniques that were identified as potential options included feedback on outcomes of behaviour, by encouraging clinicians to reflect on the impact of changing to the new phrase. This could include more constructive conversations with patients, and increased patient satisfaction. Verbal persuasion about capability was also identified as an option, encouraging clinicians to consider that this is a change which can be easily incorporated into clinical practice. The behaviour change could also be linked to professional identity (identity associate with changed behaviour BCT) and talking about the consequences of changing behaviour with peers (social comparison BCT).

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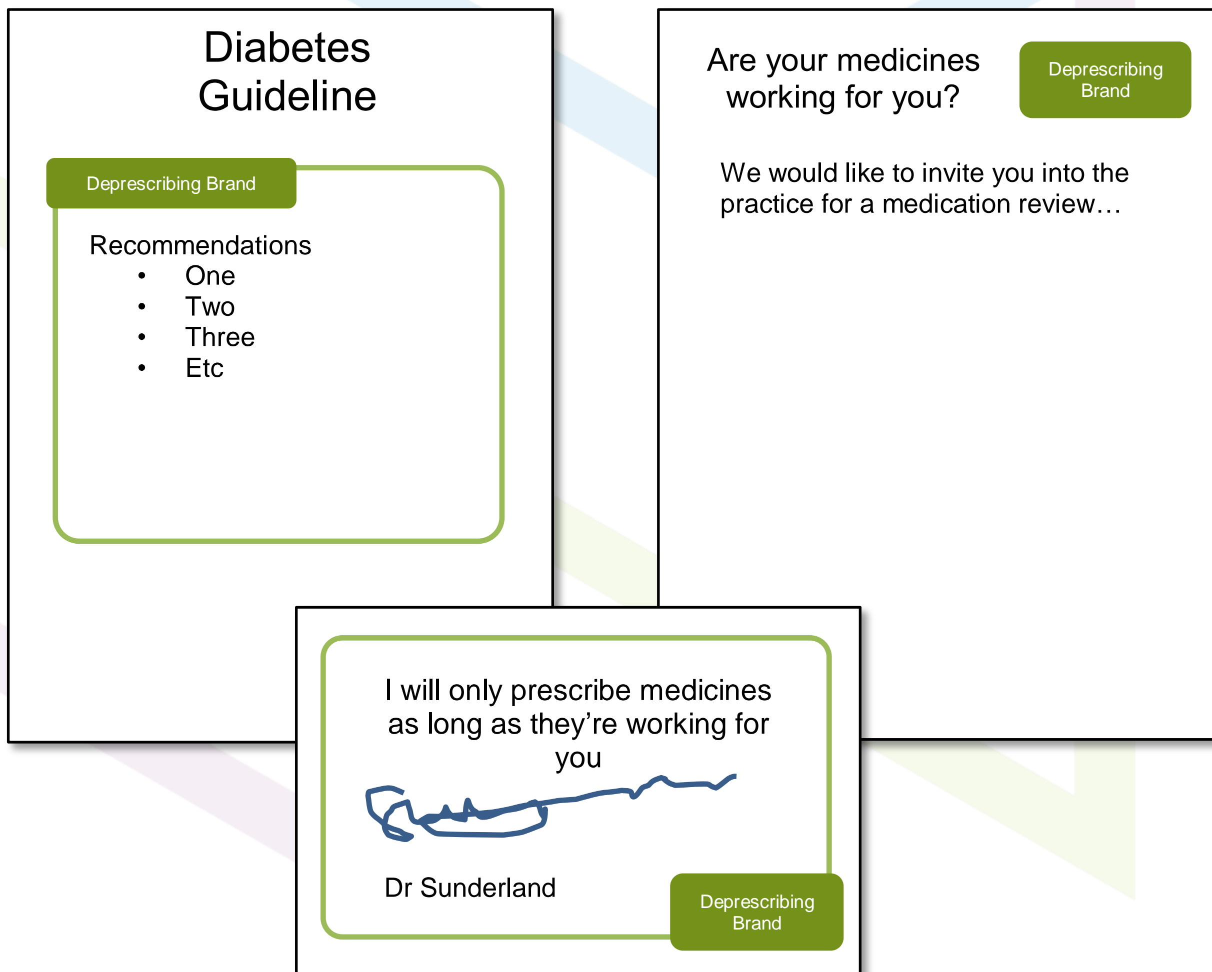
Next steps

The design ideas generated in the three groups as part of the third workshop all had common themes around increasing the visibility of the potential for deprescribing and supporting conversations about when medicines might be appropriate to stop.

The phrase "As long as it's working for you" had resonance with the creating deprescribing recommendations in clinical guidance, which placed an emphasis on clinicians asking questions about when medicines no longer seemed to be working. It was also very similar to the "are you medicines still right for you" which was generated in the communications group.

The project group have decided that the next step for this project is to work up the idea of asking if medicines are "working" into a brand which can be spread across guidelines, communications campaigns and materials to support conversations with patients. This will allow the concept of deprescribing to have a consistent visual presence. Initial concept ideas can be found below.



NHS Sunderland CCG will continue this project into the next steps to develop this brand ready for trial implementation.

Conclusions

Using a HCD approach was effective in supporting constructive and focussed conversation about how deprescribing in primary care can develop. Combining this with other structured tools and approaches such as NGT, AGREE II and BCW allowed clear ideas and themes to emerge which supported the design process and led to the final idea concept. It is hoped that this grounded approach to design will support the development and implementation of an effective deprescribing brand and programme of work to get started with deprescribing in primary care.

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